TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMS

PART 147
REIMBURSEMENT FOR NURSING COSTS FOR GERIATRIC FACILITIES

Section

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AUTHORITY: Implementing and authorized by Articles III, IV, V, VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].

SOURCE: Recodified from 89 Ill. Adm. Code 140.900 thru 140.912 and 140.Table H and 140.Table I at 12 Ill. Reg. 6956; amended at 13 Ill. Reg. 559, effective January 1, 1989; amended at 13 Ill. Reg. 7043, effective April 24, 1989; emergency amendment at 13 Ill. Reg. 10999, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 16796, effective October 13, 1989; amended at 14 Ill. Reg. 210, effective December 21, 1989; emergency amendment at 14 Ill. Reg. 6915, effective April 19, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 9523, effective June 4, 1990, for a maximum of 150 days; emergency expired November 1, 1990; emergency amendment at 14 Ill. Reg. 14203, effective August 16, 1990, for a maximum of 150 days; emergency expired January 13, 1991; emergency amendment at 14 Ill. Reg. 15578, effective September 11, 1990, for a maximum of 150 days; emergency expired February 8, 1991; amended at 14 Ill. Reg. 16669, effective September 27, 1990; amended at 15 Ill. Reg. 2715, effective January 30, 1991; amended at 15 Ill. Reg. 3058, effective February 5, 1991; amended at 15 Ill. Reg. 6238, effective April 18, 1991; amended at 15 Ill. Reg. 7162, effective April 30, 1991; amended at 15 Ill. Reg. 9001, effective June 17, 1991; amended at 15 Ill. Reg. 13390, effective August 28, 1991; emergency amendment at 15 Ill. Reg. 16435, effective October 22, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 4035, effective March 4, 1992; amended at 16 Ill. Reg. 6479, effective March 20, 1992; emergency amendment at 16 Ill. Reg. 13361, effective August 14, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 14233, effective August 31, 1992; amended at 16 Ill. Reg. 17332, effective November 6, 1992; amended at 17 Ill. Reg. 1128, effective January 12, 1993; amended at 17 Ill. Reg. 8486, effective June 1, 1993; amended at 17 Ill. Reg. 13498, effective August 6, 1993; emergency amendment at 17 Ill. Reg. 15189, effective September 2, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 2405, effective January 25, 1994; amended at 18 Ill. Reg. 4271, effective March 4, 1994; amended at 19 Ill. Reg. 7944, effective June 5, 1995; amended at 20 Ill. Reg. 6953, effective May 6, 1996; amended at 21 Ill. Reg. 12203, effective August 22, 1997; amended at 26 Ill. Reg. 3093, effective February 15, 2002; emergency amendment at 27 Ill. Reg. 10863, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18680, effective November 26, 2003; expedited correction at 28 Ill. Reg. 4992, effective November 26, 2003; emergency amendment at 29 Ill. Reg. 10266, effective

July 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 18913, effective November 4, 2005; amended at 30 Ill. Reg. 15141, effective September 11, 2006; expedited correction at 31 Ill. Reg. 7409, effective September 11, 2006; amended at 31 Ill. Reg. _____, effective June 11, 2007.

Section 147.5 Minimum Data Set-Mental Health (MDS-MH) Based Reimbursement System

a) For Class I Institution for Mental Diseases (IMDs), until data can be collected and the payment methodology implemented using the Illinois Minimum Data Set-Mental Health (IL MDS-MH), appropriate for the care needs of the IMD resident population, as described in Table B of this Part, the nursing component shall be the rate in effect on July 1, 2006. The payment methodology using the IL MDS-MH shall be implemented on July 1, 2010.

b) To receive payment based on Table B, Class I IMDs shall obtain software that produces the Mental Health Assessment Protocols, outcome measures, and quality indicators, which are part of the MDS-MH system, and train staff to utilize this clinical information in resident treatment and care planning.

c) The nursing component of the rate shall be calculated annually and may be adjusted semi-annually. The determination of rates shall be based upon a composite of MDS-MH data collected from each eligible resident in accordance with Table B for those eligible residents who are recorded in the Department's Medicaid Management Information System as of 30 days prior to the rate period as present in the facility on the last day of the six-month period preceding the rate period. Residents for whom MDS-MH resident identification information is missing or inaccurate, or for whom there is no current MDS-MH record for that period, shall be placed in the lowest MDS-MH acuity level for calculation purposes for that rate period. The nursing component of the rate may be adjusted on a semi-annual basis if any of the following conditions are met:

1) Total variable nursing time for a rate period as calculated in subsection (d)(1) of this Section exceeds total variable nursing time calculated for the previous rate period by more than five percent.

2) Total variable nursing time for a rate period as calculated in subsection (d)(1) of this Section exceeds:

A) total variable nursing time as calculated for the annual rate period by more than 10 percent;

B) total variable nursing time as recalculated and adjusted for the annual period by more than five percent.

3) Total variable nursing time for a rate period as calculated in subsection (d)(1) of this Section declines from the total variable nursing time as calculated for the annual period by more than five percent. No semi-

annual nursing component rate reduction shall exceed five percent from the annual rate determination.

d) Per diem reimbursement rates for nursing care in nursing facilities consist of three elements: variable time reimbursement; fringe benefit reimbursement; and reimbursement for supplies, consultants, medical directors and nursing directors.

1) Variable Time Reimbursement. Variable nursing time is that time necessary to meet the major service needs of residents that vary due to their physical or mental conditions. Each need level or specific nursing service measured by the MDS-MH is associated with an amount of time and staff level (Table B). Reimbursement is developed by multiplying the time for each service by the wages of the type of staff performing the service, except for occupational therapy, physical therapy and speech therapy. If more than one level of staff are involved in delivering a service, reimbursement for that service will be weighted by the wage and number of minutes allocated to each staff type. In calculating a facility's rate, the figures used by the Department for wages will be determined in the following manner:

A) The mean wages for the applicable staff levels (licensed staff, RNs, LPNs, certified nursing assistants (CNAs), social workers), as reported on the cost reports and determined by regional rate area, will be the mean wages.

B) Fringe benefits shall be calculated in accordance with Section 147.150(c)(1)(B).

C) The base wage shall be calculated in accordance with Section 147.150(c)(1)(C).

D) Special minimum wage factor shall be calculated in accordance with Section 147.150(c)(1)(D).

E) Beginning July 1, 2010, Class I IMDs shall be paid a rate based upon the sum of the following:

i) The facility MDS-MH system based rate multiplied by a ratio the numerator of which is the quotient obtained by dividing the funds appropriated specifically to pay for rates based upon the MDS-MH methodology by the total number of Medicaid patient days utilized by facilities covered by the MDS-MH based system and the denominator of which

is the difference between the weighted mean rate obtained by the MDS-MH methodology and the weighted mean rate direct care rate for IMDs in effect on July 1, 2006.

ii) The facility rate in effect on July 1, 2006, multiplied by one minus the ratio computed in subsection (d)(1)(E)(i).

2) Vacation, sick leave and holiday time shall be calculated in accordance with Section 147.150(c)(2).

3) Special supplies, consultants and the Director of Nursing shall be calculated in accordance with Section 147.150(c)(3).

e) Determination of Facility Rates
An amount for each resident will be calculated by multiplying the number of minutes from the assessment by the appropriate wages for each assessment item (see subsection(d)(1) of this Section), adding the amounts for vacation, sick and holiday time (see Section 147.150(c)(2)), and supplies, consultants, and the Director of Nursing (see Section 147.150(c)(3)). The average of the rates for eligible residents assessed will become the facility's per diem reimbursement rate for each eligible resident in the facility.

f) In order to code any item on the MDS-MH and receive subsequent reimbursement according to Table B, Class I IMDs shall follow all criteria and specific guidelines in the IL MDS-MH manual (Hirdes et al., RAI-MH Training Manual and Resource Guide 2.0, Toronto, Ontario Joint Policy and Planning Committee, 2003).

g) In order for services to qualify for reimbursement according to Table B, Class I IMDs shall maintain a minimum ratio for Psychiatric Rehabilitation Services Coordinator staff of one for every 20 residents.

h) The Department shall not pay for any new admissions to the Class I IMDs who are age 60 years or older or do not have a severe mental illness as determined by the State's mental health pre-admission screening program.

i) Service providers under Section L, Service Utilization/Treatments, of the MDS-MH shall be coded in column A when services are delivered by staff employed by the facility. Column B shall be coded for services delivered by outside individuals not employed by the facility. The Medicaid rate shall reflect only those services delivered by staff that is employed by the facility.

j) The Medicaid rate determined by Table B for Class I IMDs shall be the combination of a nursing component and socio-development component.

k) The Department of Healthcare and Family Services and the Department of Human Services-Division of Mental Health shall have the right of entry and inspection to all Class I IMD facilities in order to assess resident mix, monitor data quality, develop service quality indicators, and conduct studies, such as staff time samples, in order to test and refine the payment method.

(Source: Amended at 31 Ill. Reg. _____, effective June 11, 2007)

Section 147.15 Comprehensive Resident Assessment (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.25 Functional Needs and Restorative Care (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.50 Service Needs (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.75 Definitions (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.100 Reconsiderations (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.105 Midnight Census Report

a) The census recorded must reflect the complete activities which took place in the 24 hour period from midnight to midnight.

b) The facility is required to compile a midnight census report daily. The information to be contained in the report includes:

1) Total licensed capacity.

2) Current number of residents in-house.

3) Names and disposition of residents not present in facility, i.e. therapeutic home visit, home visit, hospital (payable bedhold), hospital (non-payable bedhold), other.

(Source: Amended at 18 Ill. Reg. 4271, effective March 4, 1994)

Section 147.125 Nursing Facility Resident Assessment Instrument

a) Except as specified in subsection (b) of this Section, all Medicaid certified nursing facilities shall comply with the provisions of the current federal Long Term Care Resident Assessment Instrument User's Manual, version 2. (Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 (December 2005), and the Resident Assessment Instrument-Mental Health Illinois version 2 (July 2003), adopted from Minimum Data Set-Mental Health version 2. This incorporation by reference includes no later amendments or editions.)

b) Nursing facilities shall, in addition, comply with the following requirements:

1) Complete a full Minimum Data Set (MDS) assessment, which includes required items A through R, in addition to any State required items, for each resident quarterly, regardless of the resident's payment source. Facilities are not required to complete and submit the MDS Quarterly Assessment Form. When completing the full MDS assessment for quarterly submittal to the Department, it is not necessary to also complete the Resident Assessment Protocols (RAPs) or Section T. RAPs and Section T are only required with the comprehensive assessment described in the current federal Long Term Care Resident Assessment Instrument User's Manual, which includes assessments completed at admission, annually, for a significant change or for a significant correction of a prior MDS.

2) Transmit electronically to the State MDS database the MDS for all assessments within 31 days after the completion date of the assessment. Except for nursing facilities that are defined as Class I Institutions for Mental Diseases (IMDs) pursuant to 89 Ill. Adm. Code 145.30, the rate set will be based on the MDS received two quarters prior to the rate effective date and MDS not received within 31 days will be given a default rate.

c) While a new rate system referenced in Section 147.150 is under development, Medicaid-certified Class I IMDs shall electronically submit both the MDS pursuant to subsections (a) and (b) of this Section and the Illinois Minimum Data Set-Mental Health (IL MDS-MH) as specified by the Department at the following frequencies:

1) Complete a full IL MDS-MH within 14 days after admission for each resident, regardless of the resident's payment source.

2) Complete a full IL MDS-MH at 90 days after admission for each resident, regardless of the resident's payment source.

3) Complete a full IL MDS-MH at six months after admission for each resident, regardless of the resident's payment source, and every six months thereafter.

4) Transmit electronically to the Department's IL MDS-MH database, the IL MDS-MH for all required assessments within 31 days after the completion date of the assessment.

(Source: Amended at 30 Ill. Reg. 15141, effective September 11, 2006; expedited correction at 31 Ill. Reg. 7409, effective September 11, 2006)

Section 147.150 Minimum Data Set (MDS) Based Reimbursement System

a) Public Act 92-0848 requires the Department to implement, effective July 1, 2003, a payment methodology for the nursing component of the rate paid to nursing facilities. Except for nursing facilities that are defined as Class I Institutions for Mental Diseases (IMDs) pursuant to 89 Ill. Adm. Code 145.30, reimbursement for the nursing component shall be calculated using the Minimum Data Set (MDS). Increased reimbursement under this payment methodology shall be paid only if specific appropriation for this purpose is enacted by the General Assembly. For Class I IMDs, the nursing component shall be the rate in effect on June 30, 2005 until a payment methodology using the Illinois Minimum Data Set-Mental Health (IL MDS-MH), appropriate for the care needs of the IMD resident population, is implemented. The payment methodology using the IL MDS-MH shall be implemented no later than July 1, 2007.

b) The nursing component of the rate shall be calculated annually and may be adjusted quarterly. The determination of rates shall be based upon a composite of MDS data collected from each eligible resident in accordance with Section 147.Table A for those eligible residents who are recorded in the Department's Medicaid Management Information System as of 30 days prior to the rate period as present in the facility on the last day of the second quarter preceding the rate period. Residents for whom MDS resident identification information is missing or inaccurate, or for whom there is no current MDS record for that quarter, shall be placed in the lowest MDS acuity level for calculation purposes for that quarter. The nursing component of the rate may be adjusted on a quarterly basis if any of the following conditions are met:

1) Total variable nursing time for a rate quarter as calculated in subsection (c)(1) of this Section exceeds total variable nursing time calculated for the previous rate quarter by more than five percent.

2) Total variable nursing time for a rate quarter as calculated in subsection (c)(1) of this Section exceeds:

A) total variable nursing time as calculated for the annual rate period by more than ten percent;

B) total variable nursing time as recalculated and adjusted for the annual period by more than five percent.

3) Total variable nursing time for a rate quarter as calculated in subsection (c)(1) of this Section declines from the total variable nursing time as calculated for the annual period by more than five percent. No quarterly

nursing component rate reduction shall exceed five percent from the previous rate quarter.

c) Per diem reimbursement rates for nursing care in nursing facilities consist of three elements: variable time reimbursement; fringe benefit reimbursement; and reimbursement for supplies, consultants, medical directors and nursing directors.

1) Variable Time Reimbursement. Variable nursing time is that time necessary to meet the major service needs of residents that vary due to their physical or mental conditions. Each need level or specific nursing service measured by the Resident Assessment Instrument is associated with an amount of time and staff level (Section 147.Table A). Reimbursement is developed by multiplying the time for each service by the wage(s) of the type of staff performing the service except for occupational therapy, physical therapy and speech therapy. If more than one level of staff are involved in delivering a service, reimbursement for that service will be weighted by the wage and number of minutes allocated to each staff type. In calculating a facility's rate, the figures used by the Department for wages will be determined in the following manner:

A) The mean wages for the applicable staff levels (RNs, LPNs, certified nursing assistants (CNAs), activity staff, social workers), as reported on the cost reports and determined by regional rate area, will be the mean wages.

B) Fringe benefits will be the average percentage of benefits to actual salaries of all nursing facilities based upon cost reports filed pursuant to 89 Ill. Adm. Code 140.543. Fringe benefits will be added to the mean wage.

C) The base wage, including fringe benefits, will then be updated for inflation from the time period for which the wage data are available to the midpoint of the rate year to recognize projected base wage changes.

D) Special minimum wage factor. The process used in subsection (c)(1)(A) of this Section to determine regional mean wages for RNs, LPNs and CNAs will include a minimum wage factor. For those facilities below 90% of the Statewide average, the wage is replaced by 90% of the Statewide average.

E) Beginning January 1, 2007, facilities shall be paid a rate based upon the sum of the following:

i) the facility MDS-based rate multiplied by the ratio the numerator of which is the quotient obtained by dividing the additional funds appropriated specifically to pay for rates based upon the MDS nursing component methodology above the December 31, 2006 funding by the total number of Medicaid patient days utilized by facilities covered by the MDS-based system and the denominator of which is the difference between the weighted mean rate obtained by the MDS-based methodology and the weighted mean rate in effect on December 31, 2006.

ii) the facility rate in effect on December 31, 2006, which is defined as the facility rate in effect on December 31, 2006 plus the Exceptional Care per diem computed in 89 Ill. Adm. Code 140.569(a)(1), multiplied by one minus the ratio computed in Section 147.150(c)(1)(E)(i). The Exceptional Care reimbursement per diem effective January 1, 2007 computed in 89 Ill. Adm. Code 140.569 shall be included in the nursing component of the June 30, 2006 rate unless the total variable nursing time for a rate quarter as calculated in subsection (c)(1) of this Section is more than a five percent drop from the total variable nursing time calculated for the June 30, 2006 rate quarter. Then the facility will receive for the rate period zero percent of the Exceptional Care reimbursement per diem computed in 89 Ill. Adm. Code 140.569

F) The amount of new funds allocated for MDS reimbursement methodology for Fiscal Year 2007, beginning January 1, 2007, is $30 million.

2) Vacation, Sick Leave and Holiday Time. The time to be added for vacation, sick leave, and holidays will be determined by multiplying the total of Variable Time by 5%.

3) Special Supplies, Consultants and the Director of Nursing. Reimbursement will be made for health care and program supplies, consultants required by the Department of Public Health (including the Medical Director), and the Director of Nursing by applying a factor to variable time and vacation, sick leave and holiday time. (A list of consultants required by the Department of Public Health can be found in 77 Ill. Adm. Code 300.830).

A) Supplies will be updated for inflation using the General Services Inflator (see 89 Ill. Adm. Code 140.551). Health care and program salaries shall be updated for inflation using the Nursing and Program Inflator (see 89 Ill. Adm. Code 140.552). A factor for supplies will be the Statewide mean of the ratio of total facility health care and programs supply costs to total facility health care and programs salaries.

B) The Director of Nursing and the consultants will be updated for inflation using the Nursing and Program Inflator (see 89 Ill. Adm. Code 140.552). A factor for the Director of Nursing and consultant costs shall be the Statewide mean of the ratio of all facilities' Director of Nursing and consultant costs to total facility health care and programs salaries.

C) These costs shall be updated pursuant to cost reports as referenced in 89 Ill. Adm. Code 153.125(f).

d) Determination of Facility Rates.
An amount for each resident will be calculated by multiplying the number of minutes from the assessment by the appropriate wages for each assessment item (see subsection (c)(1) of this Section), adding the amounts for vacation, sick and holiday time (see subsection (c)(2) of this Section), and supplies, consultants, and the Director of Nursing (see subsection (c)(3) of this Section). The average of the rates for eligible residents assessed will become the facility's per diem reimbursement rate for each eligible resident in the facility.

e) A transition period from the payment methodology in effect on June 30, 2003 to the payment methodology in effect July 1, 2003 shall be provided for a period not exceeding December 31, 2006, as follows:

1) MDS-based rate adjustments under this Section shall not be effective until the attainment of a threshold. The threshold shall be attained at the earlier of either:

A) when all nursing facilities have established a rate (sum of all components) which is no less than the rate effective June 30, 2002, or

B) January 1, 2007.

2) For a facility that would receive a lower nursing component rate per resident day under the payment methodology effective July 1, 2003 than the facility received June 30, 2003, the nursing component rate per resident day for the facility shall be held at the level in effect on June 30, 2003 until a higher nursing component rate of reimbursement is achieved by that facility.

3) For a facility that would receive a higher nursing component rate per resident day under the payment methodology in effect on July 1, 2003 than the facility received June 30, 2003, the nursing component rate per resident day for the facility shall be adjusted based on the payment methodology in effect July 1, 2003.

4) Notwithstanding subsections (e)(2) and (3) of this Section, the nursing component rate per resident day for the facility shall be adjusted in accordance with subsection (c)(1)(E) of this Section.

(Source: Amended at 30 Ill. Reg. 15141, effective September 11, 2006; expedited correction at 31 Ill. Reg. _____, effective September 11, 2006)

Section 147.175 Minimum Data Set (MDS) Integrity

a) The Department shall conduct reviews to determine the accuracy of resident assessment information transmitted in the Minimum Data Set (MDS) that are relevant to the determination of reimbursement rates. Such reviews may, at the discretion of the Department, be conducted electronically or in the facility.

b) The Department shall quarterly select, at random, a number of facilities in which to conduct on-site reviews. In addition, the Department may select facilities for on-site review based upon facility characteristics, past performance, or the Department's experience.

c) Electronic review. The Department shall conduct quarterly an electronic review of MDS data for eligible individuals to identify facilities for on-site review.

d) On-site review. The Department shall conduct an on-site review of MDS data for eligible individuals.

1) On-site reviews may be conducted with respect to residents or facilities that are identified pursuant to subsection (b) or (c) of this Section. Such review may include, but shall not be limited to, the following:

A) Review of resident records and supporting documentation, as identified in Section 147.200, observation and interview, to determine the accuracy of data relevant to the determination of reimbursement rates.

B) Review and collection of information necessary to assess the need for a specific service or care area.

C) Review and collection of information from the facility that will establish the direct care staffing level.

2) The number of residents in any selected facility for whom information is reviewed may, at the sole discretion of the Department, be limited or expanded**.**

3) Upon the conclusion of any review, the Department shall conduct a meeting with facility management to discuss preliminary conclusions of the review. If facility management disagrees with those preliminary conclusions, facility management may, at that time, provide additional documentation to support their position.

e) Corrective action. Upon the conclusion of the review and the consideration of any subsequent supporting documentation provided by the facility, the Department shall notify the facility of its final conclusions, both with respect to accuracy of data and recalculation of the facility's reimbursement rate.

1) Data Accuracy

A) Final conclusions with respect to inaccurate data shall be referred to the Department of Public Health.

B) The Department, in collaboration with the Department of Public Health, shall make available additional training in the completion of resident assessments and the coding and transmission of MDS records.

2) Recalculation of Reimbursement Rate. The Department shall determine if reported MDS data or facility staffing data that were subsequently determined to be unverifiable would cause the direct care component of the facility§s rate to be calculated differently when using the accurate data. No change in reimbursement required as a result of a review shall take effect before July 1, 2004. A facility's rate shall only be recalculated on those residents who have been subject to a Department review. A facility§s rate will be subject to change if the recalculation of the direct care component rate, as a result of using MDS data that are verifiable

A) Increases the rate by more than one percent. The rate is to be changed, retroactive to the beginning of the rate period, to the recalculated rate.

B) Decreases the rate by more than one percent. The rate is to be changed, retroactive to the beginning of the rate period, to the recalculated rate.

C) Decreases the rate by more than ten percent in addition to the rate change specified in this subsection (e)(2). The direct care component of the rate shall be reduced, retroactive to the beginning of the rate period, by $1 for each whole percentage decrease in excess of two percent.

3) Any evidence or suspicion of deliberate falsification or misrepresentation of MDS data shall be referred to the Department's Inspector General and the Department of Public Health.

f) Appeals. Facilities disputing any rate change may request a hearing pursuant to 89 Ill. Adm. Code 140.830.

(Source: Amended at 30 Ill. Reg. 15141, effective September 11, 2006; expedited correction at 31 Ill. Reg. _____, effective September 11, 2006)

Section 147.200 Minimum Data Set (MDS) On-Site Review Documentation

a) Pursuant to Section 147.175, Department staff shall conduct on-site reviews of Minimum Data Set (MDS) data to determine the accuracy of resident information that is relevant to the determination of reimbursement rates. Each nursing facility shall make accessible to the Department all provider, resident and other records necessary to determine that the needs of the resident are being met, and to determine the appropriateness of services. The Department shall provide for a program of delegated utilization review and quality assurance. The Department may contract with Medical Peer Review organizations to provide utilization review and quality assurance.

b) There shall be documentation in the resident's record to support an MDS coded response indicating that the condition or activity was present or occurred during the observation or look back period. Directions provided by the RAI User's Manual (as described in Section 147.125) are the basis for all coding of the MDS. Section S is reserved for additional State-defined items. All documentation requirements pertain to the MDS 2.0 and Section S items.

c) Each nursing facility shall ensure that MDS data for each resident accurately and completely describes the resident's condition, as documented in the resident's clinical records, maintained by the nursing facility, and the clinical records shall be current, accurate and in sufficient detail to support the reported resident data.

d) Documentation guidance has been compiled from the RAI Manual, instructions that are present on the MDS 2.0 form itself, RAI-MH, and Illinois additional documentation requirements. If later guidance is released by CMS that contradicts or augments guidance provided in this Section, the more current information from CMS becomes the acceptable standard. If additional ICD9 codes are published, they will be reviewed for appropriateness.

e) Documentation from all disciplines and all portions of the resident's clinical record may be used to verify an MDS item response. All supporting documentation shall be found in the facility during an on-site visit.

f) All conditions or treatments shall have been present or occurred within the designated observation period. Documentation in the clinical record shall consistently support the item response and reflect care related to the symptom/problem. Documentation shall apply to the appropriate observation period and reflect the resident's status on all shifts. In addition, the problems that are identified by the DS item responses that affect the resident's status shall be addressed on the care plan. Insufficient or inaccurate documentation may result in a determination that the MDS item response submitted could not be validated.

g) Disease Diagnoses

1) Code only those diseases or infections that have a relationship to the resident's current ADL (Activities of Daily Living) status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death as directed in the RAI Manual.

2) The disease conditions require a physician-documented diagnosis in the clinical record. It is good clinical practice to have the resident's physician provide supporting documentation for any diagnosis.

3) Do not include conditions that have been resolved or no longer affect the resident's functioning or care plan. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status.

h) Activities of Daily Living (ADL)
Facilities shall maintain documentation that supports the coding of Section G, Physical Functioning, and Structural Problems on the MDS during the assessment reference period. The documentation shall show the MDS coded level of resident self-performance and support has been met.

i) Restorative specific documentation shall include:

1) Documentation shall define the resident's needs and identify a restorative nursing plan of care to assist the resident in reaching and/or maintaining his or her highest level of functioning. Documentation shall contain objective and measurable information so that progress, maintenance or regression can be recognized.

2) Goals shall be resident specific, realistic, and measurable. The resident's endurance and ability to participate in the programs shall be addressed.

3) Written evidence of measurable objectives and interventions shall be in the resident's care plan, reviewed quarterly, and revised as necessary.

4) Written evidence of quarterly evaluation by a licensed nurse shall be in the clinical record.

5) There shall be written evidence that staff carrying out the programs have been trained in techniques that promote resident involvement in the activity.

6) There shall be written evidence that techniques are carried out or supervised by members of the nursing staff.

7) Sometimes under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. If a volunteer is assigned to a specific resident, there shall be written evidence of specific training in techniques that promote that resident's involvement in the restorative program.

8) Restorative programs shall be ongoing, unless there is written justification in the clinical record that supports the need to discontinue the program.

9) The number of minutes per day spent in a restorative program shall be documented for each resident and for each restorative program during the look back period.

10) The medical record shall also include documentation that restorative nursing services were administered as planned.

11) An assessment designed by the Department shall be required quarterly to assess the resident's endurance and ability to benefit from two or more restorative programs.

12) A splint or brace is defined as an appliance for the fixation, union or protection of an injured part of the body.

13) A check and change program will not be scored as a toileting program.

14) All restorative programs provided per criteria of the RAI manual shall be coded on the MDS.

j) Discharge Planning
Social services shall document monthly on the resident's potential for discharge, specific steps being taken toward discharge, and the progress being made. Social Service documentation shall demonstrate realistic evaluation, planning, and follow-through. Discharge plans shall address the current functional status of the resident, medical nursing needs, and the availability of family and/or community resources to meet the needs of the resident.

k) Psychosocial Adaptation Services

Behavioral symptoms shall be assessed and tracked during the look back period. They shall be addressed in the care plan with individualized goals and interventions.

l) Skills Training
Skills training is specific methods for assisting residents who need and can benefit from this training to address identified deficits and reach personal and clinical goals. To qualify for reimbursement, the provision of skills training shall meet all of the following criteria:

1) Skills and capabilities shall be assessed with the use of a standardized skills assessment, a cognitive assessment and an assessment of motivational potential. The assessment of motivational potential will assist in determining the type and size of the group in which a resident is capable of learning.

2) Addresses identified skill deficits related to goals noted in the treatment plan.

3) Skills training shall be provided by facility staff, trained in leading skills groups, who are paid by the facility.

4) Training shall be provided in a private room with no other programs or activities going on at the same time. The environment shall be conducive to learning in terms of comfort, noise, and other distractions.

5) Training shall be provided in groups no larger than ten, with reduced group size for residents requiring special attention due to cognitive, motivational or clinical issues, as determined by the skills assessment, cognition and motivational potential. Individual sessions can be provided as appropriate and shall be identified in the care plan.

6) Training shall utilize a well-developed, structured curriculum and specific written content developed in advance to guide each of the sessions. (Published skills modules developed for the severe mentally ill (SMI) and Mental Illness/Substance Abuse (MISA) populations are available for use and as models).

7) The curriculum shall address discrete sets of skill competencies, breaking skills down into smaller components or steps in relation to residents' learning needs.

8) The specific written content shall provide the rationale for learning, connecting skill acquisition to resident goals.

9) Training shall employ skill demonstration/modeling, auditory and visual presentation methods, role-playing and skill practice, immediate positive and corrective feedback, frequent repetition of new material, practice assignments between training sessions (homework), and brief review of material from each previous session.

10) There shall be opportunities for cued skill practice and generalization outside session as identified in the care plan and at least weekly documentation relative to skill acquisition.

11) Each training session shall be provided and attended in increments of a minimum of 30 minutes each (not counting time to assemble and settle) at least three times per week. Occasional absences are allowable, with individual coverage of missed material as necessary.

m) Close and Constant Observations
Coding of this item is intended only for interventions applied in response to the specific current significant need of an individual resident. This item should not be coded for observation conducted as standard facility policy for all residents, such as for all new admissions, or as part of routine facility procedures, such as for all returns from hospital or conducted as a part of periodic resident headcounts.

n) Ancillary Provider Services

1) Ancillary provider services are services that are provided by direct non-facility psychiatric service providers in order to meet 77 Ill. Adm. Code 300, Subpart S requirements.

2) Psychiatric rehabilitation services that are provided by non-facility providers or an outside entity shall meet the needs of the SMI resident as determined by the resident's individual treatment plan (ITP).

3) Facilities must ensure compliance with 77 Ill. Adm. Code 300.4050 when utilizing non-facility or outside ancillary providers.

o) Psychotropic Medication Monitoring
Facilities are to follow documentation guidelines as directed by 42 CFR 483.25(l) (State Operations Manual tags F329, F330, F331).

p) Dementia Care Unit

1) If the resident has a CPS score of five, care planning shall address the resident's participation in the unit's activities.

2) If a particular resident does not participate in at least an average of four activities per day over a one-week period, the unit director shall evaluate the resident's participation and have the available activities modified and/or consult with the interdisciplinary team.

3) Documentation shall support staff's efforts to involve the resident.

q) Exceptional Care Services

1) Extensive Respiratory Services

A) A respiratory therapist shall evaluate the status of the resident at least monthly if the resident has a tracheostomy.

B) Documentation of respiratory therapy being provided 15 minutes a day shall be present in the clinical record for the look back period.

C) Respiratory therapy requires documentation in the record of the treatment and the times given by a qualified professional (respiratory therapist or trained nurse) as defined in the RAI manual.

2) Documentation shall be in place to support weaning from the ventilator.

3) Ventilator Care

A) If the facility has residents receiving ventilator care, the facility shall have a respiratory therapist available at the facility or on call 24 hours a day.

B) A respiratory therapist shall evaluate and document the status of the resident at least weekly.

4) Morbid Obesity

A) A dietician's evaluation shall be completed with evidence of on-going consultation.

B) On-going monitoring of weight shall be evident.

C) The psychosocial needs related to weight issues shall be identified and addressed.

5) Wound Care Services
Facilities are to follow documentation guidelines as directed by 42 CFR 483.25(c) (State Operations Manual tag F314).

6) Traumatic Brain Injury (TBI)

A) Documentation shall support that psychological therapy is being delivered by licensed mental health professionals, as described in the RAI manual.

B) Documentation shall support a Special Symptom Evaluation program as an ongoing, comprehensive, interdisciplinary evaluation of behavioral symptoms as described in the RAI manual.

C) Documentation shall support evaluation by a licensed mental health specialist in the last 90 days. This shall include an assessment of a mood, behavior disorder, or other mental health problems by a qualified clinical professional as described in the RAI manual.

D) The care plan shall address the behaviors of the resident and the interventions used.

r) Clarification and additional documentation requirements are as follows:

1) Defined actions such as further assessment or documentation, described in the RAI Manual as "good clinical practice" are required by the Department as supporting documentation. Clinical documentation that contributes to identification and communication of a resident's problems, needs and strengths, that monitors his or her condition on an on-going basis, and that records treatments and response to treatment is a matter of good clinical practice and is an expectation of trained and licensed health care professionals (RAI page 1-23).

2) The facility shall have in place policies and procedures to address specific care needs of the residents, written evidence of ongoing in-services for staff related to residents' specific care needs and all necessary durable medical equipment to sustain life and carry out the plan of care as

designed by the physician. In the absence of the above, a referral will be made to the Illinois Department of Public Health.

3) No specific types of documentation or specific forms are mandated, but documentation shall be sufficient to support the codes recorded on the MDS. Treatments and services ordered and coded shall be documented as delivered in the clinical record.

4) When completing a significant change assessment, the guidelines provided in the RAI Manual shall be followed. This includes documenting "the initial identification of a significant change in terms of the resident's clinical status in the progress notes" as described in RAI page 2-7.

(Source: Old Section repealed at 27 Ill. Reg. 18680, effective November 26, 2003; new Section added at 30 Ill. Reg. 15141, effective September 11, 2006; expedited correction at 31 Ill. Reg. _____, effective September 11, 2006)

Section 147.205 Nursing Rates (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.250 Costs Associated with the Omnibus Budget Reconciliation Act of 1987 (P.L.100-203) (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.300 Payment to Nursing Facilities Serving Persons with Mental Illness

a) Reimbursement rates for nursing facilities (ICF and SNF) for program costs associated with the delivery of psychiatric rehabilitation services to residents with mental illness will remain at the level in effect on January 1, 2001, except as may otherwise be provided by 305 ILCS 5/5-5.4 and 89 Ill. Adm. Code 153.

b) Payment for services provided by nursing facilities for residents who have a primary diagnosis of mental illness will be dependent upon the facility meeting all criteria specified in 77 Ill. Adm. Code 300.4000 through 300.4090.

(Source: Amended at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.301 Sanctions for Noncompliance

Based on a finding of noncompliance by the Department of Public Health on the part of a nursing facility with any requirement for providing services to persons with mental illness pursuant to 77 Ill. Adm. Code 300.4000 through 300.4090, the Department may take action to terminate or suspend the facility pursuant to 89 Ill. Adm. Code 140.16 and 140.19 or recommend to the Department of Public Health imposition of any of the remedies or penalties available under the Nursing Home Care Act [220 ILCS 45/3-101].

(Source: Added at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.305 Psychiatric Rehabilitation Service Requirements for Individuals With Mental Illness in Residential Facilities (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.310 Inspection of Care (IOC) Review Criteria for the Evaluation of Psychiatric Rehabilitation Services in Residential Facilities for Individuals with Mental Illness (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 25, 2002)

Section 147.315 Comprehensive Functional Assessments and Reassessments (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093 effective February 15, 2002)

Section 147.320 Interdisciplinary Team (IDT) (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.325 Comprehensive Program Plan (CPP) (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.330 Specialized Care – Administration of Psychopharmacologic Drugs (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.335 Specialized Care – Behavioral Emergencies (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.340 Discharge Planning (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.345 Reimbursement for Program Costs in Nursing Facilities Providing Psychiatric Rehabilitation Services for Individuals with Mental Illness (Repealed)

(Source: Repealed at 26 Ill. Reg. 3093, effective February 15, 2002)

Section 147.350 Reimbursement for Additional Program Costs Associated With Providing Specialized Services for Individuals with Developmental Disabilities in Nursing Facilities

a) Nursing facilities (ICF and SNF) providing specialized services to individuals with developmental disabilities, excluding state operated facilities for the developmentally disabled, will be reimbursed for providing a specialized services program for each client with developmental disabilities as specified in 89 Ill. Adm. Code 144.50 through 144.250.

b) Beginning February 1, 1990, facility reimbursement for providing specialized services to individuals with developmental disabilities will be made upon conclusion of resident reviews that are conducted by the state's mental health authority or their contracted agent. Facility reimbursement for providing specialized services as a result of resident reviews concluded prior to February 1, 1990, will begin with the facility's February billing cycle.

c) The additional reimbursement for costs associated with specialized services programs is based upon the presence of three (3) determinants. The three determinants are:

1) Minimum Staffing

A) Direct Services – Facilities must be in compliance with the Health Care Financing Administration's (HCFA) (42 CFR 442.201 or 42 CFR 442.302 (1989)) and the Illinois Department of Public Health's (IDPH) (77 Ill. Adm. Code 300.1230) minimum staffing standards relative to facility type.

B) The number of additional direct services staff necessary for delivering adequate specialized services programs for individuals with developmental disabilities is based upon a full time equivalent (FTE) staff to client ratio of 1:7.5.

2) Qualified Mental Retardation Professional Services

A) Each individual's specialized services program must be integrated, coordinated and monitored by a Qualified Mental Retardation Professional (QMRP). Any facility required to provide specialized services programs to individuals with developmental disabilities must provide QMRP services. Delivery of these services is based upon a full-time equivalent ratio of one (1) QMRP to thirty (30) individuals being served.

B) A Qualified Mental Retardation Professional (QMRP) is a person who has at least one year of experience working directly with persons with mental retardation and is one of the following:

i) A doctor of medicine or osteopathy;

ii) A registered nurse;

iii) An individual who holds at least a bachelor's degree in one of the following professional categories: Occupational Therapist; Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, Psychologist, Master's Degree; Social Worker; Speech-Language Pathologist or Audioligist; Recreation Specialist; Registered Dietitian; and Human Services, including but not limited to Sociology, Special Education, Rehabilitation Counseling, and Psychology (42 CFR 483.430(1989)).

3) Assessment and Other Program Services

A) A comprehensive functional assessment that identifies an individual's needs must be performed as needed to supplement any preliminary evaluations conducted prior to admission to a nursing facility.

B) A Comprehensive Assessment must include:

i) physical development and health;

ii) dental examination that includes an assessment of oral hygiene practices;

iii) nutritional status;

iv) sensorimotor development/auditory functioning;

v) social development;

vi) speech and language development;

vii) adaptive behaviors or independent living skills necessary for the individual to be able to function in the community (Scales of Independent Behavior (SIB) or the Inventory for

Client and Agency Planning (ICAP) are the assessment instruments that must be used for this assessment);

viii) vocational or educational skills (if applicable);

ix) cognitive development;

x) medication and immunization history;

xi) psychological evaluation (within 5 years) that includes an assessment of the individual's emotional and intellectual status;

xii) capabilities and preferences relative to recreation/leisure activities;

xiii) other assessments indicated by the individual's needs, such as physical and occupational therapy assessments;

xiv) seizure disorder history (if applicable) with information regarding frequency of occurrence and classification; and

xv) screenings (the facility performs or obtains) in the areas of nutrition, vision, auditory and speech/language.

d) Costs associated with specialized services programs reimbursement includes other program costs such as consultants, inservice training, and other items necessary for the delivery of specialized services to clients in accordance with their individual program plans.

e) Total program reimbursement for the additional costs associated with the delivery of specialized services to individuals with developmental disabilities residing in nursing facilities will be ten dollars ($10) per day, per individual being served. Facility eligibility for specialized services program reimbursement is dependent upon the facility meeting all criteria specified in Sections 147.5 through 147.205, 147.350 and 144.25 through 144.250.

(Source: Amended at 16 Ill. Reg. 17332, effective November 6, 1992)

Section 147.TABLE A Staff Time (in Minutes) and Allocation by Need Level

a) Effective July 1, 2003, each Medicare and Medicaid certified nursing facility shall complete, and transmit quarterly to the Department, a full Minimum Data Set (MDS) for each resident who resides in a certified bed, regardless of payment source. A description of the MDS items referenced in the tables found following subsection (e) of this Table A are contained in the Long Term Care Resident Assessment Instrument User's Manual available from the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 (December 2002).

b) Table A identifies 51 MDS items that shall be used to calculate a profile on each Medicaid-eligible resident within each facility.

c) The profile for each Medicaid-eligible resident shall then be blended to determine the nursing component of the nursing facility's Medicaid rate.

d) Each MDS item in Table A includes a description of the item and the variable time referred to in Section 147.150(c)(1). The variable time assigned to each level represents the type of staff that should be delivering the service (unlicensed, licensed, social worker and activity) and the number of minutes allotted to that service item.

e) Following is a listing of the 51 reimbursable MDS items found in Table A.

1) Base Social Work and Activity

2) Activities of Daily Living (ADL)

3) Restorative Programs

PROM

AROM

Splint/Brace

Bed Mobility

Mobility/Transfer

Walking

Dressing/Grooming

Eating

Prosthetic Care

Communication

Other Restorative

Scheduled Toileting

4) Medical Services

Continence Care

Catheter Care

Bladder Retraining

Pressure Ulcer Prevention

Moderate Skin Care Services

Intensive Skin Care Services

Ostomy Care

IV Therapy

Injections

Oxygen Therapy

Chemotherapy

Dialysis

Blood Glucose Monitoring

End Stage Care

Infectious Disease

Acute Medical Conditions

Pain Management

Discharge Planning

Nutrition

Hydration

5) Mental Health (MH) Services

Psychosocial Adaptation

Psychotropic Medication Monitoring

Psychiatric Services (Section S)

Skills Training

Close or Constant Observation

6) Dementia Services

Cognitive Impairment/Memory Assistance

Dementia Care Unit

7) Exceptional Care Services

Extensive Respiratory Services

Ventilator Care

Total Weaning From Ventilator

Morbid Obesity

Complex Wound Care

Traumatic Brain Injury (TBI)

8) Special Patient Need Factors:

Communication: add 1% of staff time accrued for ADLs through Exceptional Care Services

Vision Problems: add 2% of staff time accrued for ADLs through Exceptional Care Services

Accident/Fall Prevention: add 3% of staff time accrued for ADLs through Exceptional Care Services

Restraint Free Care: add 2% of staff time accrued for ADLs through Exceptional Care Services

Activities: add 2% of staff time accrued for ADLs through Exceptional Care Services

MDS ITEMS AND ASSOCIATED STAFF TIMES

Throughout Table A, where multiple levels are identified, only the highest level shall be scored.

1) Base Social Work and Activity

Level		Unlicensed	Licensed	Social Worker	Activity
I	All Clients	0	0	5	10

2) Activities of Daily Living

Level	Composite Scores	Unlicensed	Licensed	Social Worker	Activity
I	Composite 7-8	50	7.5 RN 7.5 LPN		
II	Composite 9-11	62	9.5 RN 9.5 LPN		
III	Composite 12-14	69	10.5 RN 10.5 LPN		
IV	Composite 15-29	85	12.5 RN 12.5 LPN		

ADL Scoring Chart for the above Composite Levels

MDS values equal to "-" denote missing data.

ADL	MDS items	Description	Score
Bed Mobility	G1aA = - or G1aA = 0 or G1aA = 1.	Self-Performance = missing Self-Performance = independent Self-Performance = supervision	1
	G1aA = 2.	Self-Performance = limited assistance	3
	G1aA = 3 or G1aA = 4 or G1aA = 8 AND G1aB = - or G1aB = 0 or G1aB = 1 or G1aB = 2.	Self-Performance = extensive assistance Self-Performance = total dependence Self-Performance = activity did not occur Support = missing Support = no set up or physical help Support = set up help only Support = 1 person assist	4
	G1aB = 3 or G1aB = 8.	Support = 2+ person physical assist Support = activity did not occur	5

Transfer	G1bA = - or G1bA = 0 or G1bA = 1.	Self-Performance = missing Self-Performance = independent Self-Performance = supervision	1
	G1bA = 2.	Self-Performance = limited assistance	3
	G1bA = 3 or G1bA = 4 or G1bA = 8 AND G1bB = - or G1bB = 0 or G1bB = 1 or G1bB = 2.	Self-Performance = extensive assistance Self-Performance = total dependence Self-Performance = activity did not occur Support = missing Support = no set up or physical help Support = set up help only Support = 1 person assist	4
	G1bB = 3 or G1bB = 8.	Support = 2+ person physical assist Support = activity did not occur	5

Locomotion	G1eA = - or G1eA = 0 or G1eA = 1.	Self-Performance = missing Self-Performance = independent Self-Performance = supervision	1
	G1eA = 2.	Self-Performance = limited assistance	3

	G1eA = 3 or	Self-Performance = extensive assistance	
	G1eA = 4 or	Self-Performance = total dependence	
	G1eA = 8 AND	Self-Performance = activity did not occur	
	G1eB = - or	Support = missing	4
	G1eB = 0 or	Support = no set up or physical help	
	G1eB = 1 or	Support = set up help only	
	G1eB = 2.	Support = 1 person assist	
	G1eB = 3 or	Support = 2+ person physical assist	5
	G1eB = 8.	Support = activity did not occur	

Toilet	G1iA = - or	Self-Performance = missing	
	G1iA = 0 or	Self-Performance = independent	1
	G1iA = 1.	Self-Performance = supervision	
	G1iA = 2.	Self-Performance = limited assistance	3
	G1iA = 3 or	Self-Performance = extensive assistance	
	G1iA = 4 or	Self-Performance = total dependence	
	G1iA = 8 AND	Self-Performance = activity did not occur	
	G1iB = - or	Support = missing	4
	G1iB = 0 or	Support = no set up or physical help	
	G1iB = 1 or	Support = set up help only	
	G1iB = 2.	Support = 1 person assist	
	G1iB = 3 or	Support = 2+ person physical assist	5
	G1iB = 8.	Support = activity did not occur	

Dressing	G1gA = - or	Self-Performance = missing	
	G1gA = 0 or	Self-Performance = independent	1
	G1gA = 1.	Self-Performance = supervision	
	G1gA = 2.	Self-Performance = limited assistance	2
	G1gA = 3 or	Self-Performance = extensive assistance	
	G1gA = 4 or	Self-Performance = total dependence	3
	G1gA = 8.	Self-Performance = activity did not occur	

Hygiene	G1jA = - or	Self-Performance = missing	
	G1jA = 0 or	Self-Performance = independent	1
	G1jA = 1.	Self-Performance = supervision	

	G1jA = 2.	Self-Performance = limited assistance	2
	G1jA = 3 or G1jA = 4 or G1jA = 8.	Self-Performance = extensive assistance Self-Performance = total dependence Self-Performance = activity did not occur	3

Eating	G1hA = - or G1hA = 0 or G1hA = 1.	Self-Performance = missing Self-Performance = independent Self-Performance = supervision	1
	G1hA = 2.	Self-Performance = limited assistance	2
	G1hA = 3 or G1hA = 4 or G1hA = 8	Self-Performance = extensive assistance Self-Performance = total dependence Self-Performance = activity did not occur	3
	Or		
	K5a = 1 or K5b = 1 and Intake = 1	Parenteral/IV in last 7 days Tube feeding in last 7 days See below	
	Where		
	Intake = 1 if		
	K6a = 3 or	Parenteral/enteral intake 51-75% of total calories	
	K6a = 4	Parenteral/enteral intake 76-100% of total calories	
	Or Intake = 1 if		
	K6a = 2 and	Parenteral/enteral intake 26-50% of total calories	
	K6b = 2 or	Average fluid intake by IV or tube is 501-1000 cc/day	
	K6b = 3 or	Average fluid intake by IV or tube is 1001-1500 cc/day	
	K6b = 4 or	Average fluid intake by IV or tube is 1501-2000 cc/day	

	K6b = 5.	Average fluid intake by IV or tube is 2001 or more cc/day	

3) Restorative Programs

With the exception of amputation/prosthesis care and splint or brace assistance restoratives, the total number of restorative programs eligible for reimbursement shall be limited to five, with no more than three being a Level II restorative. Scheduled toileting shall be included in this limit. Splint or brace assistance and amputation/prosthesis care shall be reimbursed independently. A resident coded in I1t (CVA/stroke) on the MDS and also coded as B4≤2 (cognitive skills for decision making) shall be limited to a total of six restoratives with no more than four being a Level II restorative. A Department designed assessment shall be required quarterly to assess the resident's endurance and the resident's ability to benefit from two or more restorative programs.

When the number of restoratives coded on the MDS exceeds the allowable limits for reimbursement, the following order shall be used.

A) Eating Restorative

B) Scheduled Toileting

C) Walking Restorative

D) Transfer Restorative

E) PROM

F) Bed Mobility Restorative

G) Communication Restorative

H) Dressing/Grooming Restorative

I) Other Restorative

J) AROM

Passive Range of Motion

Lev	MDS items	Description	Unl	Lic	SW	Act

	G4aA > 0 or G4bA > 0 or G4cA > 0 or G4dA > 0 or G4eA > 0 or G4fA > 0 or G4aB > 0 or G4bB > 0 or G4cB > 0 or G4dB > 0 or G4eB > 0 or G4fB > 0	Any function limits in ROM of neck Any function limits in ROM of arm Any function limits in ROM of hand Any function limits in ROM of leg Any function limits in ROM of foot Any function limits in ROM of other limitation or loss Any function limits in voluntary movement of neck Any function limits in voluntary movement of arm Any function limits in voluntary movement of hand Any function limits in voluntary movement of leg Any function limits in voluntary movement of foot Any function limits in voluntary movement of other limitation or loss				
	AND					
I	3 ≤ P3a ≤ 5	3 to 5 days of PROM rehab	10	3 RN 3 LPN		
II	6 ≤ P3a ≤ 7	6 to 7 days of PROM rehab	15	3 RN 3 LPN		

Active Range of Motion

Lev	MDS items	Description	Unl	Lic	SW	Act
	G4aA > 0 or	Any function limits in ROM of neck				
	G4bA > 0 or	Any function limits in ROM of arm				
	G4cA > 0 or	Any function limits in ROM of hand				
	G4dA > 0 or	Any function limits in ROM of leg				
	G4eA > 0 or	Any function limits in ROM of foot				
	G4fA > 0 or	Any function limits in ROM of other limitation or loss				
	G4aB > 0 or	Any function limits in voluntary movement of neck				
	G4bB > 0 or	Any function limits in voluntary movement of arm				
	G4cB > 0 or	Any function limits in voluntary movement of hand				
	G4dB > 0 or	Any function limits in voluntary movement of leg				
	G4eB > 0 or	Any function limits in voluntary movement of foot				
	G4fB > 0	Any function limits in voluntary movement of other limitation or loss				
	AND					
I	3 ≤ P3b ≤ 5	3 to 5 days of AROM rehab	8	2 RN 2 LPN		
II	6 ≤ P3b ≤ 7	6 to 7 days of AROM rehab	12	2 RN 2 LPN		

Splint/Brace Assistance

Lev	MDS items	Description	Unl	Lic	SW	Act
I	3 ≤ P3c ≤ 5	3 to 5 days of assistance	8	2 RN 2 LPN		
II	6 ≤ P3c ≤ 7	6 to 7 days of assistance	12	2 RN 2 LPN		

Bed Mobility Restorative

Lev	MDS items	Description	Unl	Lic	SW	Act
	0 < G1aA < 8 AND G7 = 1	Need assistance in bed mobility Some or all ADL tasks broken into subtasks				
	AND					
I	3 ≤ P3d ≤ 5	3 to 5 days of rehab or restorative techniques	10	3 RN 3 LPN		
II	6 ≤ P3d ≤ 7	6 to 7 days of rehab or restorative techniques	15	3 RN 3 LPN		

Mobility (Transfer) Restorative

Lev	MDS items	Description	Unl	Lic	SW	Act
	0 < G1bA < 8 AND G7 = 1	Need assistance in transfer Some or all ADL tasks broken into subtasks				
	AND					

I	3 ≤ P3e ≤ 5	3 to 5 days of rehab or restorative techniques	10	3 RN 3 LPN		
II	6 ≤ P3e ≤ 7	6 to 7 days of rehab or restorative techniques	15	3 RN 3 LPN		

Walking Restorative

Lev	MDS items	Description	Unl	Lic	S W	Act
	0 < G1cA < 8 or	Need assistance in walking in room				
	0 < G1dA < 8 or	Need assistance in walking in corridor				
	0 < G1eA < 8 or	Need assistance in locomotion on unit				
	0 < G1fA < 8 AND	Need assistance in locomotion off unit				
	G7 = 1	Some or all ADL tasks broken into subtasks				
	AND					
I	3 ≤ P3f ≤ 5	3 to 5 days of rehab or restorative techniques	10	3 RN 3 LPN		
II	6 ≤ P3f ≤ 7	6 to 7 days of rehab or restorative techniques	15	3 RN 3 LPN		

Dressing or Grooming Restorative

Lev	MDS items	Description	Unl	Lic	SW	Act
	0 < G1gA < 8 or	Need assistance in dressing				
	0<G1jA<8 AND	Need assistance in personal hygiene				

	G7 = 1 AND	Some or all ADL tasks broken into subtasks				
	B4 ≤ 2	Cognitive skills for decision making				
	AND					
	S1 = 0 AND	Does not meet IDPH Subpart S Criteria				
I	3 ≤ P3g ≤ 5	3 to 5 days of rehab or restorative techniques	10	3 RN 3 LPN		
II	6 ≤ P3g ≤ 7	6 to 7 days of rehab or restorative techniques	15	3 RN 3 LPN		

Eating Restorative

Lev	MDS items	Description	Unl	Lic	SW	Act
	0 < G1hA < 8 or K1b = 1 AND G7 = 1	Need assistance in eating Has swallowing problem Some or all ADL tasks broken into subtasks				
	AND					
I	3 ≤ P3h ≤ 5	3 to 5 days of rehab or restorative techniques	15	3 RN 3 LPN		
II	6 ≤ P3h ≤ 7	6 to 7 days of rehab or restorative techniques	20	3 RN 3 LPN		

Amputation/Prosthetic Care

Lev	MDS items	Description	Unl	Lic	SW	Act
I	3 ≤ P3i ≤ 5	3 to 5 days of assistance	10	3 RN 3 LPN		
II	6 ≤ P3i ≤ 7	6 to 7 days of assistance	15	3 RN 3 LPN		

Communication Restorative

Lev	MDS items	Description	Unl	Lic	SW	Act
	C4 > 0	Deficit in making self understood				
	AND					
I	3 ≤ P3j ≤ 5	3 to 5 days of rehab or restorative techniques	10	3 RN 3 LPN		
II	6 ≤ P3j ≤ 7	6 to 7 days of rehab or restorative techniques	15	3 RN 3 LPN		

Other Restorative

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P3k=3 or greater AND Q2 < 2 AND	Other Restorative Improved or no change in care needs	6	5 RN 5 LPN		

	B2a = 0 AND B4 = 0 or 1 AND C6 = 0 or 1 AND S1 = 0	Short term memory okay Cognitive skills for decision making Ability to understand others Does not meet IDPH Subpart S criteria				
II	P3k = 3 or greater AND Q1c = 1 or 2 AND Q2 < 2 AND P1ar = 1 AND B2a = 0 AND B4 = 0 or 1 AND C6 = 0 or 1 AND S1 = 0	Other restorative Stay projected to be of a short duration – discharge expected to be within 90 days Improved or no change in care needs Provide training to return to the community Short-term memory Cognitive skills for decision making Ability to understand others Does not meet IDPH Subpart S criteria	6	7.5 RN 7.5 LPN		

Other Restorative shall only be reimbursed for a total of two quarters regardless of the level.

Scheduled Toileting

Lev	MDS items	Description	Unl	Lic	SW	Act

I	H3a = 1 AND H3b = 0 AND H3d = 0 AND H1b > 1 or GliA> 1 and <8	Any scheduled toileting plan No bladder retraining program No indwelling catheter Incontinent at least 2 or more times a week Self-performance = limited to total assistance	22	1.5 RN 1.5 LPN		

4) Medical Services

Continence Care

Lev	MDS items	Description	Unl	Lic	SW	Act
I	Catheter Care H3d = 1 AND H3a = 0	 Indwelling catheter present No scheduled toileting plan	12	.5 RN .5 LPN		
II	Bladder Retraining H3b = 1 AND H3a = 0 AND	 Bladder retraining program No scheduled toileting plan	32	5 RN 5 LPN		

	H1b > 1 AND B4 = 0 or 1 OR H3b = 1 AND H3a = 0 AND H1b ≤ 1 AND H4 = 1 AND B4 = 0 or 1	Incontinent at least 2 or more times a week Cognitive skills for decision making Bladder retraining program No scheduled toileting plan Bladder continence Change in continence Cognitive skills in decision making				

Bladder scanners cannot be the sole content of the program. Continence Care – Level II (Bladder Retraining) shall only be reimbursed for two quarters.

Pressure Ulcer Prevention

Lev	MDS items	Description	Unl	Lic	SW	Act
I	M3 = 1 or Any two of: M5a M5b M5c M5d M5i	History of resolved ulcers in last 90 days Pressure relieving devices for chair Pressure relieving devices for bed Turning or repositioning program Nutrition or hydration intervention for skin Other prevention for skin (other than feet)	15	4 RN 4 LPN		

Moderate Skin Care/Intensive Skin Care

Lev	MDS items	Description	Unl	Lic	SW	Act
I		Moderate Skin Care Services	5	5 RN		
	M1a > 0 or	Stage 1 ulcers		5 LPN		
	M1b > 0 or	Stage 2 ulcers				
	Any of:	Other Skin Problems (below):				
	M4a = 1	Abrasions, bruises				
	M4b = 1	Burns				
	M4c = 1	Open lesions other than ulcers				
	M4d = 1	Rashes				
	M4e = 1	Skin desensitized to pain or pressure				
	M4f = 1	Skin tears or cuts (other than surgery)				
	M4g = 1 AND	Surgical wounds				
	4 of the following:	Skin Treatments (below):				
	M5a = 1	Pressure relieving devices for chair				
	M5b = 1	Pressure relieving devices for bed				
	M5c = 1	Turning or repositioning program				
	M5d = 1	Nutrition or hydration intervention for skin				
	M5e = 1	Ulcer care				
	M5f = 1	Surgical wound care				
	M5g = 1	Application of dressings (other than feet)				

	M5h = 1 M5i = 1 OR (M6b = 1 or M6c = 1) AND M6f = 1	Application of ointments (other than feet) Other prevention for skin (other than feet) Infection of the foot Open lesion of the foot And application of a dressing				
II	M1c > 0 or M1d > 0 AND 4 of the following: M5a = 1 M5b = 1 M5c = 1 M5d = 1 M5e = 1 M5f = 1 M5g = 1 M5h = 1 M5i = 1	Intensive Skin Care Services Stage 3 ulcers Stage 4 ulcers Skin Treatments (below): Pressure relieving devices for chair Pressure relieving devices for bed Turning or repositioning program Nutrition or hydration intervention for skin Ulcer care Surgical wound care Application of dressings (other than feet) Application of ointments (other than feet) Other prevention for skin (other than feet)	5	15 RN 15 LPN		

Ostomy Services

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1af = 1	Ostomy care performed	5	2.5 RN 2.5 LPN		

IV Therapy

Lev	MDS items	Description	Unl	Lic	SW	Act
I	Plac = 1 or K5a = 1 AND P1ae = 1	IV medication Parenteral/IV nutrition Monitoring acute medical condition	1	15 RN 15 LPN		

Injections

Lev	MDS items	Description	Unl	Lic	SW	Act
I	O3 ≥ 2	Number of injections in last 7 days		3 RN 3 LPN		

Oxygen Therapy

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1ag = 1	Oxygen therapy administered in last 14 days	9	7.5 RN 7.5 LPN		

Chemotherapy

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1aa = 1	Chemotherapy given	1	5 RN 5 LPN		

Dialysis

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1ab = 1	Dialysis given	1	5 RN 5 LPN	2	

Blood Glucose Monitoring

Lev	MDS items	Description	Unl	Lic	SW	Act
I	I1a = 1 AND K5e = 1 or K5f = 1 or O3 = 7	Diabetes mellitus Therapeutic diet Dietary supplement Injections daily		1 RN 1 LPN		

End Stage Care

Lev	MDS items	Description	Unl	Lic	SW	Act
I	J5c = 1	End stage disease, 6 or fewer months to live Restoratives including scheduled toileting and bladder retraining sets to level '0' except AROM, PROM, splint/brace. Limit of 4 quarters	10	6 RN 6 LPN	8	

If End Stage Care has been scored, Discharge Planning shall be set to zero.

Infectious Disease

Lev	MDS items	Description	Unl	Lic	SW	Act
I	I2a = 1 or	Antibiotic resistant infection	18	8.5 RN 8.5 LPN	1	
	I2b = 1 or	Clostridium Difficile				
	12e = 1 or	Pneumonia				
	12g = 1 or	Septicemia				
	I2i = 1 or	TB				
	12 j = 1 or	Urinary Tract infection present				
	I2k = 1 or	Viral hepatitis				
	12l = 1 or	Wound infection				
	I3 = ICD9 code 041.01,133.0	Streptococcus Group A, scabies				

Acute Medical Conditions

Lev	MDS items	Description	Unl	Lic	SW	Act
I	J5b = 1 AND	Acute episode or flare-up of chronic condition	1	11.5 RN 11.5 LPN	1	
	P1ae = 1 AND	Monitoring acute medical condition				
	P1ao = 0 OR	Not hospice care				
	(J5a = 1 AND	Condition makes resident's cognitive, ADL, mood or behavior patterns unstable				
	P1ao = 0 AND	Not hospice care				

	P1ae = 1) OR (B5a = 2 or B5b = 2 or B5c = 2 or B5d = 2 or B5e = 2 or B5f = 2) AND P1ae = 1 AND P1ao = 0	Monitoring acute medical condition Easily distracted over last 7 days Periods of altered perceptions or awareness of surroundings over last 7 days Episodes of disorganized speech over last 7 days Periods of restlessness over last 7 days Periods of lethargy over last 7 days Mental function varies over course of day in last 7 days Monitoring acute medical condition Not hospice care				

Pain Management

Lev	MDS items	Description	Unl	Lic	SW	Act
I	J2a > 0 AND J2b > 0	Demonstrate or complain of pain Mild to excruciating intensity	4	4 RN 4 LPN	1	1

Discharge Planning

Lev	MDS items	Description	Unl	Lic	SW	Act

I	Q1c = 1 or 2 AND Q2 < 2 AND P1ar = 1 AND Sl=0	Stay projected to be of short duration – discharge expected to be within 90 days Improved or no change in care needs Provide training to return to community Does not meet IDPH Subpart S criteria		8 RN 8 LPN	16	

Discharge Planning shall only be reimbursed for two quarters. If End Care has been scored, Discharge Planning shall be set at zero.

Nutrition

Lev	MDS items	Description	Unl	Lic	SW	Act
I	K5h = 1 OR K5f = 1	On a planned weight change program Dietary supplement given between meals	4	1.5 RN 1.5 LPN	1	
II	K5b =1 and Intake = 1 Intake = 1 if K6a = 3 or K6a = 4 Or Intake = 1 if K6a = 2 and	Tube feeding in last 7 days See below Parenteral/ enteral intake 51-75% of total calories Parenteral/enteral intake 76-100% of total calories Parenteral/enteral intake 26-50% of total calories	0	11 RN 11 LPN	1	

	K6b = 2 or	Average fluid intake by IV or tube is 501-1000 cc/day				
	K6b = 3 or	Average fluid intake by IV or tube is 1001-1500 cc/day				
	K6b = 4 or	Average fluid intake by IV or tube is 1501-2000 cc/day				
	K6b = 5	Average fluid intake by IV or tube is 2001 or more cc/day				

Hydration

Lev	MDS items	Description	Unl	Lic	SW	Act
I	H2b = 1 or	Constipation	15	3.5 RN 3.5 LPN		1
	ICD9 = 564.00 or 564.7 AND	Constipation				
	K5a = 0 AND	No parenteral/IV				
	K5b = 0 OR	No feeding tube				
	Any two of the following separate conditions: 1 ≤ O4e ≤ 7 or	Received a diuretic medication in last 7 days				
	J1o = 1 or	Vomiting				
	I3 a,b,c,d,e = 276.5 or	Volume depletion				
	276.50 or	Volume depletion, unspecified				
	276.51 or	Dehydration				
	276.52 or	Hypovolemia				

	I2j = 1 or	Urinary tract infection in last 30 days				
	J1c = 1 or	Dehydrated				
	J1d = 1 or	Did not consume most fluids provided (3 days)				
	J1h = 1 or	Fever				
	J1j = 1 AND	Internal bleeding				
	K5a = 0 AND	Not have parenteral/IV				
	K5b = 0	No feeding tube				

5) Mental Health Services

Psychosocial Adaptation

Lev	MDS items	Description	Unl	Lic	SW	Act
I	(P2a = 1 or	Behavior symptom evaluation	12	3 RN 3 LPN	8	2
	P2b = 1 or	Evaluation by licensed MH specialist within last 90 days				
	P2c = 1 or	Group therapy				
	P2d = 1) AND	Resident specific changes to environment				
	Any E1a-p > 0 or	Indicators of depression				
	F1g = 1 or	No indicators of psychosocial well-being				
	Any F2a-g = 1 or	Any unsettled relationships				
	Any F3a-c = 1 or	Issues with past roles				
	E4aA > 0 or	Wandering in last 7 days				
	E4bA > 0 or	Verbally abusive in last 7 days				
	E4cA > 0 or	Physically abusive in last 7 days				

	E4dA > 0 or	Inappropriate or disruptive behavior in last 7 days				
	E4eA > 0 or	Resisted care in last 7 days				
	J1e= 1 or	Delusions				
	J1i = 1	Hallucinations				

Psychotropic Medication Monitoring

Lev	MDS items	Description	Unl	Lic	SW	Act
I	O4a = 7 or	Antipsychotic meds	5	2.5 RN 2.5 LPN		
	O4b = 7 or	Antianxiety meds				
	O4c = 7 or	Antidepressant meds				
	O4d = 7	Hypnotic meds				

Psychiatric Services (Section S)

Lev	MDS items	Description	Unl	Lic	SW	Act
I	S1 = 1 AND	Meets IDPH Subpart S criteria	6	1.5 RN 1.5 LPN	10	
	ADL Index = 4 AND	Activities of Daily Living Composite Score = 15-29				
	One or more of the following are coded M1c or Mld >0 or	Stage 3 or stage 4 ulcers				
	K5b = 1 or	Feeding tube				
	K5a = 1 or	Parenteral/IV				

	Plab = 1 or J5c = 1 or Plaa = 1 or Plaj = 1 or Plal = 1 AND Psychiatric Services Level II, Level III, Level IV skills training, close and constant observation, dressing/grooming and other restorative, cognitive performance, dementia care unit and discharge planning reset to zero	Dialysis End Stage Disease Chemotherapy Tracheostomy Care provided Ventilator				
II	Sl = 1 AND	Meets IDPH Subpart S criteria	13	2.5 RN 2.5 LPN	20	
	S8 = 1 AND Dressing/grooming and other restorative, cognitive performance, and dementia care unit and discharge planning reset to zero	Ancillary provider services delivered by non-facility providers				
III	Sl = 1	Meets IDPH Subpart S criteria	13	4.5	20	

	AND ADL Index=3 or 4 AND (AA3-A3a)/365.25 > 65 AND	 ADL composite score between 12-29 Resident is 65 years of age or older at time of the assessment reference date		RN 4.5 LPN		
	Dressing/grooming and other restorative, cognitive performance, and dementia care unit and discharge planning reset to zero					
IV	Sl = 1 AND S8 = 0 AND Dressing/grooming and other restorative, cognitive performance, and dementia care unit and discharge planning reset to zero	Meets IDPH Subpart S criteria Ancillary provider services delivered by facility providers	16	5 RN 5 LPN	25	

Skills Training – Section S

Lev	MDS items	Description	Unl	Lic	SW	Act
I	S5 = 1 AND S1 = 1	Skills training provided Meets IDPH Subpart S criteria	6	6 RN 6 LPN	8	6

Close or Constant Observation − Section S

Lev	MDS items	Description	Unl	Lic	SW	Act
I	S5a-e ≥ 1 AND S1 = 1	Close or constant observation Meets IDPH Subpart S criteria	6	2 RN 2 LPN	5	

6) Dementia Services

Cognitive Impairment/Memory Assistance Services

Lev	CPS items	Description	Unl	Lic	SW	Act
I	CPS = 2 AND S1 = 0	Cognitive performance scale of 2 Does not meet IDPH Subpart S criteria	6			4
II	CPS = 3 or 4 AND S1 = 0	Cognitive performance scale is 3 or 4 Does not meet IDPH Subpart S criteria	16	3 RN 3 LPN	11	10
III	CPS = 5 or 6 AND S1 = 0	Cognitive performance scale is 5 or 6 Does not meet IDPH Subpart S criteria	21	5.5 RN 5.5 LPN	16	15

Cognitive Performance Scale Codes

Scale	Description
0	Intact
1	Borderline Intact
2	Mild Impairment
3	Moderate Impairment

4	Moderate Severe Impairment
5	Severe Impairment
6	Very Severe Impairment

Impairment Count for the Cognitive Performance Scale

I code	MDS items	Description
		Note: None of B2a, B4, or C4 can be missing
IC 1	B2a = 1	Memory problem
IC 2	B4 = 1 or 2	Some dependence in cognitive skills
IC 3	$1 \leq$ C4 $\leq$ 3	Usually understood to rarely or never understood

Severe Impairment Count for the Cognitive Performance Scale

I code	MDS items	Description
		Note: None of B2a, B4, or C4 can be missing
SIC 0	Below not met	
SIC 1	B4 = 2	Moderately impaired in cognitive skills
SIC 2	C4 = 2 or 3	Sometimes understood to rarely or never understood

Cognitive Performance Scale

Scale	MDS items	Description
Coma	N1a = 0 and	Awake all or most of the time in the morning
	N1b = 0 and	Awake all or most of the time in the afternoon
	N1c = 0 and	Awake all or most of the time in the evening
	B1 = 1 and	Is comatose
	G1aA = 4 or 8 And	Bed-Mobility Self-Performance = total dependence or did not occur
	G1bA = 4 or 8 And	Transfer Self-Performance = total dependence or did not occur
	G1hA = 4 or 8 And	Eating Self-Performance = total dependence or did not occur
	G1iA = 4 or 8 And	Toilet Use Self-Performance = total dependence or did not occur
6	Not (B4 = 0,1, 2)	Not have cognitive skills independent to moderately impaired

6	B4 = 3 And G1hA = 4 or 8	Cognitive skills severely impaired Eating Self-Performance = total dependence or did not occur
5	B4 = 3 And G1hA = - or ≤ 3	Cognitive skills severely impaired Eating Self-Performance = missing to extensive assistance
4	If IC code = 2 or 3 And SIC code = 2	Some dependence in cognitive skills Usually understood to rarely or never understood Sometimes understood to rarely or never understood
3	If IC code = 2 or 3 And SIC code = 1 If IC code = 2 or 3	Some dependence in cognitive skills Usually understood to rarely or never understood Moderately impaired in cognitive skills Some dependence in cognitive skills Usually understood to rarely or never understood
2	And SIC code = 0	Better than moderate cognition skills and usually can be understood
1	If IC code = 1	Memory problem

Dementia Care Unit

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1an = 1 AND I1q = 1 or I1u = 1 AND S1 = 0 AND CPS 2,3,4,5 AND Dementia care unit is IDPH certified	Alzheimer's/Dementia special care unit Alzheimer's Disease Dementia other than Alzheimer's Does not meet IDPH Subpart S criteria CPS score	15	4 RN 4 LPN	10	10

7) Exceptional Care Services

Respiratory Services

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1ai = 1 or P1aj = 1 or P1bdA = 7	Perform suctioning Administered trach care Respiratory therapy	5	15 RN 15 LPN		
II	P1ai = 1 AND P1aj = 1 AND P1bdA > 0	Performed suctioning Administered trach care Respiratory therapy	5	22.5 RN 22.5 LPN		

A $50.00 add-on cost will be applied to all residents receiving trach care.

Ventilator Care

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1a1 = 1	Receiving ventilator care	5	35 RN 35 LPN		

A $150.00 add-on cost shall be applied to all residents receiving ventilator care. The trach add-on cost shall not be included.

Weaning From Ventilator

Lev	MDS items	Description	Unl	Lic	SW	Act
I	P1a1 = 0 on current MDS AND	Resident no longer on ventilator	5	15 RN 15 LPN		

	P1a1 = 1 on previous MDS	Resident previously on ventilator				

Morbid Obesity

Lev	MDS items	Description	Unl	Lic	SW	Act
I	I3 = 278.01 AND	ICD9 for morbid obesity is marked	20	7.5 RN 7.5 LPN	5	
	K5e = 1 AND	On a therapeutic diet				
	K5h = 1 AND	On planned weight change program				
	G1aA = 3 and	Extensive assist				
	G1aB=3 or	Requires 2+ assist with bed mobility				
	G1bA=3 and	Extensive assist				
	G1bB=3 or	Requires 2+ assist with transfers				
	G1cA=3 and	Extensive assist				
	G1cB=3 AND	Requires 2+ assist with walk in room				
	P3d=7 or	On bed mobility restorative				
	P3e=7 or	On transfer restorative				
	P3f = 7	On walking restorative				

A $40.00 add-on shall be applied to all residents meeting the Morbid Obesity category.

Complex Wounds

There are no minutes assigned to this area. It is strictly a $15.00 add-on applied to residents meeting the following criteria.

MDS item	Description
M1c or M1d ≥ 0 AND	Presence of stage 3 or 4 PU
M2a ≥ 0 or	Type of ulcer, pressure
M2b ≥ 0 AND	Type of ulcer, stasis
B1 = 1 or	Comatose
G1Aa = 3 or 4 or	Bed mobility (extensive)
G1Ab = 3 or 4	Transfer (extensive)
AND any 3 of the follow:	
ICD 9 codes of (260, 261, 262, 263.0, 263.1, 263.2, 263.8, 263.9)	ICD 9-Malnutrition
ICD 9 585	ESRD
I1a = 1	Diabetes Mellitus
I1qq = 1	Renal Failure
I1j = 1	Peripheral vascular disease
I1x = 1	Paraplegia
I1z = 1	Quadriplegia
I1w = 1	Multiple Sclerosis
J5c = 1	End stage disease
H1a = 4	Incontinence of bowel
H1b = 4	Incontinence of bladder
J1c = 1	Dehydration
G6a = 1	Bedfast
J2a = 2	Pain daily
M3 = 1	History of resolved ulcers
AND all of the following:	
M5a = 1 and/or	Pressure relieving device/chair
M5b = 1 AND	Pressure relieving device/bed

M5c = 1 AND	Turn and position
M5d = 1 AND	Nutrition or hydration
M5e = 1	Ulcer care

Traumatic Brain Injury

There are no minutes assigned to this area. It is strictly a $50.00 add-on applied to residents meeting the following criteria.

MDS item	Description
I1cc = 1 AND	Traumatic brain injury
B1 = 0 AND	Not comatose
S1 = 0 AND	Does not meet Subpart S criteria
E4aA = 3 and E4 a B = 1 or	Wandering daily and alterability
E4bA = 3 and E4bB = 1 or	Verbally abusive behavioral symptoms daily and alterability
E4cA = 3 and E4cB = 1 or	Physically abusive behavioral symptoms daily and alterability
E4dA = 3 and E4dB = 1 or	Socially inappropriate/disruptive behavioral symptoms daily and alterability
E4eA = 3 and 34eB = 1 AND	Resists care daily and alterability
P1beA = 1 AND	Psychological therapy
P2a = 1 AND	Special behavior symptom evaluation
P2b = 1	Evaluation by a mental health specialist in last 90 days

8) Special Patient Need Factors

Communication

Count	MDS items	Description	Staff Minutes
I	C4 > 0 or	Deficit in making self understood	1% of all staff time accrued in all categories from ADLs through Exceptional Care
	C6 > 0	Deficit in understanding others	

Vision Problems

Count	MDS items	Description	Staff Minutes
I	D1 > 0 or	Vision impaired to Severely impaired	2% of all staff time accrued in all categories from ADLs through Exceptional Care
	D2a = 1 or	Decreased peripheral vision	
	D2b = 1	Experience halos around lights, light flashes	

Accident/Fall Prevention

Count	MDS items	Description	Staff Minutes
I	I1aa = 1 or	Seizure disorder	3% of all staff time accrued in all categories from ADLs through Exceptional Care
	O4a-d = 7 or	Medications	
	H1b > 0 or	Incontinent urine	
	J1f = 1 or	Dizziness	
	J4a = 1 or	Fell in past 30 days	
	J4b = 1 or	Fell in past 31-180 days	
	J1n = 1 or	Has unsteady gait	
	E4aA > 0	Wandered in last 7 days	

Restraint Free

Count	MDS items	Description	Staff Minutes
I		In last assessment:	
	P4c > 1 or	Used trunk restraint daily in last 7 days	2% of all staff time accrued in all categories from ADLs through Exceptional Care
	P4d > 1 or	Used limb restraint daily in last 7 days	
	P4e > 1	Used chair that prevents rising daily in last 7 days	
	And	And in current assessment:	
	P4c = 0 and	Not used trunk restraint in last 7 days	
	P4d = 0 and	Not used limb restraint in last 7 days	
	P4e = 0	Not used chair that prevents rising in last 7 days	

Activities

Count	MDS items	Description	Staff Minutes
I	N2 = 0 or 1 AND Any of the following checked:	Average time involved in activities	2% of all staff time accrued in all categories from ADLs through Exceptional Care
	G6a = 1 or	Bedfast all or most of the time	
	C4 > 1 or	Sometimes too rarely understood	
	C6 > 1 or	Sometimes too rarely understands others	

E1o > 0 or	Withdrawal from activity	
AA3 ≤ 50 or	Age is 50 or younger at assessment reference date	
E1p > 0 or	Reduced social interactions	
E4a-eA > 0 or	Any behavioral symptoms	
G4b-dB > 0 OR	Any limited ROM	
N2 = 0 or 1 AND	Average time involved in activities	
E2 > 0 AND	Mood persistence	
E1a > 0 or	Negative statements	
E1n > 0 or	Repetitive physical movements	
E4eA > 0 or	Resists care	
E1o > 0 or	Withdraws from activity	
E1p > 0 or	Reduced social interaction	

	E1j > 0 or	Unpleasant mood in morning	
	N1d =1 or	Not awake all or most of the time	
	E1g > 0 or	Statements that something terrible will happen	
	K3a = 1 or	Weight loss	
	(N1a,b,c ≤ 1 AND	Not awake all or most of the time	
	B1 =0)	Not comatose	

(Source: Amended at 30 Ill. Reg. 15141, effective September 11, 2006; expedited correction at 31 Ill. Reg. _____, effective September 11, 2006)

Section 147.TABLE B MDS-MH Staff Time (in Minutes) and Allocation by Need Level

As part of the transition to a new reimbursement system for Class I IMDs, Table B sets forth the initial criteria that may likely be used to incentivize provision of clinically appropriate services to individual residents of these facilities. The Department intends to secure data and begin analyzing this data, including a sample time study, prior to implementation of this payment model.

Each MDS-MH item in Table B includes a description of the item from the MDS-MH, and the variable time assigned to each level represents the type of staff that should be delivering the service (aide, licensed, RN, LPN and social services) and the number of minutes allotted to that service item.

MDS Item	Description of Medical Services	Aide	Licensed	RN	LPN	Social Service
	Program Base	25	11	1	1	25
G1a=2 G1=3	Hygiene 1 Hygiene 2	8 12	1 1		1 1	3 3
G1b=3 or G1c=3 G1b=4 or G1b=5 or G1c=4 or G1c=5	Mobility 1 Mobility 2	12 17		1 1	1 1	1 1
G1d=2 G1d=3	Toilet 1 Toilet 2	10 14	1 1	 1	1.5 1	1 1
G1e=2 Gle=3	Eating 1 Eating 2	10 16	1 1	 1	 1	2 1
G1f=2 G1f=3	Bathing 1 Bathing 2	10 14	2 1	 1	 1	3 2
H1=2 or H1=3	Hearing 1	3			1	3
H2=2 H2=3 or H2=4	Vision 1 Vision 2	3 3	 1		1 1	3 3
H3=2 or H3=3 H3=4	Expression 1 Expression 2	6 8	2 2			4 7

H4=2 or H4=3 H4=4	Understanding 1 Understanding 2	6 8	2 2			4 7
ICD-9=250 to 250.9	Diabetes 1	8		2	4	2
N2a=1 or N2b=1 or N2c=1 or N2d=1 or Hyperlipidemia (ICD-9=272.0 to 272.9)	Nutrition 1	5	1	1	2	2
N3a=1 or N3b=1 or N3c=1 or N4=1	Eating Disorders 1	5	3	1	2	3
L2a=1 or L2b=1 or L2c=1	Nursing Interventions 1	2		0.5	0.5	
L2a=2 or L2b=2 or L2c=2	Nursing Interventions 2	2.5	1	0.5	0.5	1
L2a=3 or L2b=3 or L2c=3	Nursing Interventions 3	3.5	1	1.5	1.5	1
L2a=4 or L2b=4 or L2c=4	Nursing Interventions 4	4.5	1	1.5	1.5	2
L2a=5 or L2b=5 or L2c=5	Nursing Interventions 5	5.5	1	2	2	2
L2a=6 or L2b=6 or L2c=6	Nursing Interventions 6	6	2	2	2	2
L2a=7 or L2b=7 or L2c=7	Nursing Interventions 7	7	2	3	2	2
CPS=3 or 4 CPS=5 or 6	Cognitive Problems 1 Cognitive Problems 2	4 6	2 3			5 7
Number of E1a to E1g scoring >1=1 or 2	Behavior Disturbance 1	5	2			5
Number of E1a to E1g scoring >1=3 or 4	Behavior Disturbance 2	10	2			8

Number of E1a to E1g scoring >1=5 or more	Behavior Disturbance 3	15	3			10
D1a=1 D1a=2 D1a=3 or D1a=4	Self Injury 1 Self Injury 2 Self Injury 3	2 3 10	 2 5	 1	 2	2 5 10
D1b=1	Intent to Kill Self 1	4	2			5
D1a=0 and D1c=1	Considered Self Injurious Act 1	5	2			1
D1a=0 and D1d=1	At Risk for Self Injury 1	2	2			5
D2a=1 D2a=2 D2a=3 or D2a=4	Violence 1 Violence 2 Violence 3	2 3 10	 2 5	 1	 2	2 5 10
D2b=1 D2b=2 D2b=3 or D2b=4	Intimidation Threats to Others 1 Intimidation Threats to Others 2 Intimidation Threats to Others 3	2 3 10	 2 5			2 5 10
D2c=2 D2c=3 or D2c=4	Violent Ideation 1 Violent Ideation 2	2 4	 2			1 7
K2b=1	Medication Support 1	6	1	1	1	5
K5>0	Acute Control Medications 1	2	1	2	2	5
M3a>0	Required Staff Accompaniment	5				2
A5a=1 or 2	Hx Crim Justice Viol 1		2			3

A5a=3 or 4	Hx Crim Justice Viol 2		4			5
A5b=1 or 2	Hx Crim Justice Nonviol 1		1			2
A5b=3 or 4	Hx Crim Justice Nonviol 2		2			4
M2a>0 or M2b>0	Close or Constant Observation 1	15	5			5
M2c>0 or M2d>0 or M2e>0	Close or Constant Observation 2	30	10			10
P3≤ 5 and L4a>1	Discharge Planning 1		10			25
L1i≥ 3	PRS Director or Coordinator Counseling					5
L3a or L3b=2 or 3 and L4aA=2 or 3 and P3<5	Community Reintegration	3	3			5
L3b=2 or 3 and L4bA=2 or 3	Social/Family Functioning	3	3			12
L3b or L3d + 2 or 3 and L4cA=2 or 3	Psych Rehab/ Recover Readiness and Support	3	4			15
L3b=2 or 3 and L4dA=2 or 3	Skills Training and Generalization	5	5			20
L3a, L3b or L3d=2 or 3 and L4eA=2 or 3 and C1>1 or C2=2	Substance Use/Abuse Management	6	5			15
L3a or L3b=2 or 3 and L4fA=2 or 3	Vocational/ Academic Development	2	3			12
L3a or L3b + 2 or 3	Aggression/Anger		5			15

and L4gA=2 or 3 and D2a=2 or D2b=3 or D2c=3 or Elc>1	Management					
L3a or L3b=2 or 3 and L4hA=2 and E1b or E1d or E1e>0	Behavior Management	2	3			13
L3b=2 and L4iA=2	Enhanced Activity Program	5	3			12
L3a or L3b=2 and L4jA=2	Work Program (Department of Labor Compliant)		5			25
L3b=2 or 3 and L4kA=2 or 3	Illness Self-Management (SAMHSA Toolkit)	5	5			20
L3a and L3b=2 or 3 and L41A=2 or 3	Specialized Therapies (DBT)		5			25
L5=1	Adherence with Programs 1	10	4			10
L6≥1	Required staff accompaniment to medical appointment mandated by the outside medical provider	10				
Psychotropic Medications as Listed in Section R	Psychotropic Medication Monitoring	7		8	8	

Compute Cognition Category Using Cognitive Performance Scale (CPS)	
Compute Intermediate Cognition Variables	

Count of Non-Independence Items for CPS (Cog1)	If (F1a=1) add 1 to Cog 1
	If (F2=1 or 2 or 3) add 1 to Cog 1
	If (H3=1 or 2 or 3 or 4) add 1 to Cog 1

Count of Moderate to Severe Impairments for CPS (Cog 2)	If (F2=2 or 3) add 1 to Cog 2 If (H3=3 or 4) add 1 to Cog 2
Compute CPS	
Compute CPS Level 1	If (Cog 1=1) CPS=1
Compute CPS Level 2	If (Cog 1=2 or 3 and Cog 2=0) CPS=2
Compute CPS Level 3	If (Cog 1=2 or 3 and Cog 2=1) CPS=3
Compute CPS Level 4	If (Cog 1=2 or 3 and Cog 2=2) CPS=4
Compute CPS Level 5	If (F2=4 or 5 and G1e <6) CPS=5
Compute CPS Level 6	If (F2=4 or 5 and G1e=6 or 8) CPS=6
Convert CPS to Cognition Reimbursement Categories	

(Source: Amended at 31 Ill. Reg. _____, effective June 11, 2007)

Section 147.TABLE C Comprehensive Resident Assessment (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE D Functional Needs and Restorative Care (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE E Service (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE F Social Services (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE G Therapy Services (Repealed)

(Source: Repealed at 17 Ill. Reg. 13498, effective August 6, 1993)

Section 147.TABLE H Determinations (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE I Activities (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE J Signatures (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE K Rehabilitation Services (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)

Section 147.TABLE L Personal Information (Repealed)

(Source: Repealed at 27 Ill. Reg. 18680, effective November 26, 2003)